MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Wednesday, January 16, 2002
9:34 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item: Indirect medical education payments above the costs of teaching -- Craig Lisk

MR. LISK: Good morning. I'm going to go a little bit more into more specific concerning Julian's discussion and the discussion you had now about the IME adjustment and the amount of the IME payments that are above the costs of teaching in the current payment system.

Teaching hospitals have historically had higher costs than other hospitals and Medicare IME payments are intended to pay for the higher costs of teaching hospitals. The IME adjustment was provided, back at the beginning of the prospective payment system, in light of doubts of the inability of the inpatient PPS to fully capture factors such as greater patient severity that might account for these higher costs in teaching hospitals. The adjustment is an add-on to the base payment rate so it's adjusted depending upon what the per case base payment rate is for a specific case.

These payments total somewhere between $4 billion and $5 billion currently.

The adjustment, though, is set well above the current cost relationship. It's more than twice the empirical cost relationship between our measure of teaching intensity, resident-to-bed, and costs per case, Medicare inpatient costs per case.

Inpatient operating costs per case increase about 3.2 percent for every 10 percent increase in their resident-to-bed ratio but the adjustment in 2002 is set at 6.5 percent. That's been the adjustment level that we've had since 1999.

In fiscal year 2003, though, the adjustment will drop to 5.5 percent as part of policy changes that are from the BBA and as this adjustment has been deferred over a number of years to finally it will be reduced to 5.5 percent.

But this next table will provide you some information on the IME adjustment under alternative scenarios. To give you some idea of the size of the adjustment that these hospitals receive currently, what they will next year, and then what really the empirical level says, and if we're going to pay closer to what the cost relationship is for Medicare.

As you can see, these are substantial payments. So a hospital with an IRB of 0.5 currently receives an adjustment of about 29 percent currently. The empirical cost relationship is about 17 percent. So there's a substantial amount of payments above the cost relationship here for these hospitals.

To give you some idea, though, about particular hospitals and the size of the IME adjustment, I'll give some ideas of some competitor hospitals for some of our commissioners. The University of Chicago Hospital, for instance, has an IRB of .75. Mt. Sinai has an IRB of about .56, but your competitor --

DR. ROWE: For historical interest only.

MR. LISK: Of historical interest, yes. But Montefiore has

an IRB of .75, for instance. If you get down to hospitals that are around the .25 area, you have like St. Raphael in Connecticut, which is a competitor to Yale New Haven Hospital. If you talk about even lower numbers, .10 is something like Maine Medical Center is an example of that. So that just gives you an idea of the types of hospitals and where they fall in that distribution.

But this next chart here shows you the frequency distribution of hospitals by IME adjustment percentage. As you see, almost half of all hospitals receive less than a 5 percent increase bump up in their payment due to the IME adjustment of teaching hospitals. However, 10 percent of teaching hospitals receive more than a 25 percent boost in payments from the IME adjustment. So it's a substantial portion of the teaching hospitals. That's more than 200 teaching hospitals overall.

You have to remember, this is saying what the boost in payment is from the IME adjustment. Many of these hospitals are also receiving DSH payments and stuff. So their payments above the base rate are substantial. So those are the amounts that are, in terms of above the cost relationship.

So this translates into potentially much higher margins for these major teaching hospitals. As this next chart shows, it shows into greater financial performance under the Medicare program.

There still is wide variation and overlap in inpatient margins, but the red line shows the Medicare inpatient margin for major teaching hospitals in 1999. As you can see, they have substantially higher inpatient margins than other hospitals. And for performance for other teaching hospitals, which is the green line.

The aggregate inpatient margin for major teaching hospitals here in 1999 was 22 percent compared to 6.5 percent for non-teaching hospitals and 11.6 percent for other teaching hospitals.

But the IME payments above cost and DSH payments are the substantial contributor to this. As you see in the next overhead, when we remove the DSH payments and IME payments above the cost relationship, the distributions are much closer and overlap considerably.

Interestingly, though, aggregate performance for major teaching hospitals, though, is still higher than other teaching and non-teaching hospitals. The aggregate margin still for major teaching hospitals is 5.6 percent, for other teaching is 4.3 and it's 2.5 for non-teaching hospitals.

The story for total margins, though, is different. This is historically, when we get down to the IME debate, is one of the reasons why this is such a critical issue. The margin for major teaching hospitals, total margin, is 2.4 percent compared to 4 percent for other teaching and non-teaching hospitals. Now again, there's a distribution around these margins. This is just the aggregate, so there's considerable overlap in the

distribution here, as well, on total margin performance. But in aggregate, the financial performance of major teaching hospitals is lower.

What I want to talk about is the payments above the current cost relationship and what this means to these teaching hospitals. In 1999 the subsidy portion of the IME payment accounted for about 3 percent of Medicare inpatient payments. So it's a substantial portion of Medicare inpatient payments.

The subsidy portion of the IME payment accounted for 8.8 percent of Medicare inpatient payments for major teaching hospitals, so it's a large share of their inpatient margin.

The subsidy portion, though, also accounted for 1.8 percent of total revenues for major teaching hospitals. Thus, it was a major factor in helping keep major teaching hospitals total margins above zero. Without these payments, and assuming no behavioral change if they didn't have these actual subsidy payments from the IME adjustment above the cost relationship, the aggregate total margin for major teaching hospitals would have been about 0.6 in 1999. So that's an important factor.

Another thing to consider, though, is the subsidy portion of these payments will be dropping about 30 percent next year, in terms of the IME adjustment, when it's reduced.

All our discussion, when we get back to it, on the updates and the modeling we have done have all taken that into account in all of the numbers that you've seen and you saw at the last meeting. We've taken that into account, that the IME adjustment is dropping to 5.5 percent, and all the margin calculations that you'll be seeing later on. So that's just a reminder to that. We're talking about payment adequacy.

DR. ROWE: You said the subsidy piece goes down 30 percent? That's because the subsidy piece is half of the 6.5, is basically what you're saying?

MR. LISK: Correct.

DR. ROWE: But it's going to 5.5. So the total payment is going down 15 percent?

MR. LISK: Correct, absolutely.

The next overhead, in terms of other factors to consider here in determining what to do, several factors need to be considered. First is the provision of uncompensated care. Uncompensated care accounts for about 10 percent of major teaching hospitals' total costs, compared to 5 percent for other hospitals, on average. Interestingly, though, the real difference here though is between public and private. Public major teaching hospitals, their share of uncompensated care is around 30 percent. The private major teaching, on average, are very similar to the rest of the hospitals, closer to 5 percent. It may be little bit higher but it's very similar.

Again, there's a wide distribution here on provision of uncompensated care but on average the private major teaching are similar to the other hospitals. So it's the public major

teachings that, on average, have the higher burden.

Teaching hospitals, though, in relation to this also receive about two-thirds of Medicare's DSH payments. It's about one-third/one-third for major teaching and other teaching.

I'm sorry I didn't mention this, major teaching we define as hospitals with a resident-to-bed ratio of over .25. That accounts for about a quarter or 20 percent of all teaching hospitals. But on DSH payments they each account for about a third.

Interestingly though, the private payer payment-to-cost ratio for major teaching hospitals -- this is from the AHA data -- is lower for major teaching hospitals compared to other hospitals, 1.07 compared to 1.16 for other teaching and 1.24 for non-teaching. So potentially there may be some of the subsidy is going to help support lower payments from private payers is one thing we have to consider. We don't know, in terms of what actually happens and how hospitals behave, but it's interesting to note that.

Now if we look at our overall Medicare margin for major teaching hospitals, that's about 11 percent margin, I believe. So if you're looking at Medicare may be more generous than the private payers here overall for the whole facility.

Another point that I want to make though is that IME payments are not directly tied to any specific mission that the hospital has except the level of teaching intensity that the hospital has. There's no direct use of what these payments are to be used for in the payment system. That's something that Julian had brought up in his discussion, in terms of one of the factors to consider here, as well. So there's no direct system on how to say to use this.

MR. HACKBARTH: Craig, before you leave this, you've pointed out that the amount of uncompensated care in major teaching hospitals is twice as high as the other. Is it possible to do a correlation, hospital-by-hospital, of the relationship between IME payments and uncompensated care? Because even if in the aggregate the recipients of the IME have, on average, higher uncompensated care, the relationship might look very different if you go hospital-by-hospital.

MR. LISK: Unfortunately, the data we use directly for us to do it on the uncompensated care is the AHA data that we don't have direct access to, that the AHA has access to. So it's something that we'd have to figure out for them to conduct for us because we don't directly have that data.

So all this leads us to the following issues we would like you to consider. The first, should Medicare continue making extra payments to providers unrelated to the costs of caring for Medicare patients? That was one of the main issues that Julian was talking about in his presentation.

Related to that then, in the IME adjustment, is should the IME adjustment be reduced to the empirical cost relationship?

And if so, how quickly and what should be done with the savings if you wanted to?

So the options for the commission, in terms of this discussion is really to remain silent on this regarding this year's March report but study this issue more comprehensively next year in what you want to do. Now historically, on the level of the IME adjustment, ProPAC had, for instance, looked at this on a yearly basis, had recommended that the adjustment be reduced closer to the empirical level but gradually and monitor financial performance over time. I just wanted to provide that as a brief recap, but that was something that was done annually.

You could, though, if you wanted to, in this year's report, recommend reducing a subsidy portion of the IME payment for some specified period. And if you do, you'll need to decide whether to return the subsidy to the base rates or take the IME subsidy as program savings.

With that, I'd be happy to answer any questions and look forward to hearing your discussion.

DR. NEWHOUSE: Ever since I got to ProPAC I agreed with their position in principle: if Congress wants to spend the money this way, fine. But it's hard to justify.

I thought, however, there is an analysis that we could do that's not here that would shed some light on what I think is probably a relevant question. I don't think it, in fact, would be that difficult for us to do it.

The issue you alluded to, Craig, is to what degree do IME payments compensate for changes in how private payers behave. You have an interesting cut of numbers in the paper we got that you didn't put you. You have hospitals divided into four groups: those that get IME and DSH; those that get IME only; those that get DSH only; and those that get neither.

The total margins are actually highest in the hospitals that only get IME and they're lowest in the hospitals that get both IME and DSH, which I suspect is kind of minor teaching versus major teaching.

But if you took those same four groups and you looked at how total margins changed over time as IME changed, that might tell us something about whether as IME went up or down these hospitals were making adjustments in what they were charging private payers. In other words, their ability to maintain themselves as IME went down. Or DSH for that matter, I don't really want to separate the two for this purpose.

That might inform our discussion. I haven't seen that kind of analysis before, but it's analogous to what we've done with the payment-to-cost ration in general which suggests that rates that are obtained from private side do change as Medicare benefits change.

DR. ROWE: Can I comment on that point? I know we had seen the analysis, Joe. I think Julian may have shown us a kind of reciprocity or mirror image analysis about Medicare payments and

private payer payments in the past. But then I thought more recently, perhaps at the last meeting, we had seen some data that indicated that those things had not been so closely linked of late. And that in the last year or two that hadn't been the case. Is that right?

DR. NEWHOUSE: That's right.

DR. ROWE: So given that, that calls that into question. I think if you're going to do that analysis, I would be careful to pay attention to rural because I think that what happens is rural teaching hospitals -- like the University of Iowa, a very large teaching hospital in a rural area -- are indispensable in the networks of private payers and have very high payment-to-cost ratios independent of whether they're getting IME, et cetera. The rural effect would screw up that analysis unless you were paying attention to it, I think.

And I do think that since that relationship seems not to be holding most recently, we might soften the supposition that you're saying that there is this linkage.

DR. STOWERS: I think this goes back to our earlier discussion, too, but my concern lays somewhere with the other teaching. And looking at total margins in 1999, I would assume based on the 6.5 percent, that was being received at that time. You know, we have a 2.4 for major teaching, other teaching of 4 and non-teaching of 4. It just makes me wonder why it makes sense at that point, when we've come to that kind of a balance for teaching and non-teaching, that we would not be making a recommendation to hold it to 6.5 percent rather than allow to go on down to the 5.5, taking into everything into consideration if we're going to look at total margins.

Now I know that gets back to looking at Medicare margins versus total again, but let alone be talking about taking more and more of the subsidy, why when we're at that level of balance between 80 percent of the hospitals, which is the other teaching -- and as Jack said, very instrumental in the broader area across the country to maintain a supply of health care providers.

So as we look at this, I'm just wondering why we're talking on down lower and lower.

MR. HACKBARTH: It sounds to me like you're applying a little bit different test than Bob was talking about when you look at total margins. What I heard Bob suggest was that total margins are relevant when you're looking at the issue of preserving access to care for Medicare beneficiaries. What I hear you suggesting is well, we ought to be looking for equality or rough equality in total margins. Those are very different tests.

DR. STOWERS: I realize that. But I think if we are looking at access and these other teaching hospitals are instrumental throughout a broad area. So if we do look at purely from access, I'm just wondering why we would not still apply something to margins there, as to where we are. It would seem that we had

come to some kind of a balance at 6.5 and yet the majority of the discussion is still on cutting the subsidy more and more. So it would seem to me we were about right at the 6.5.

DR. REISCHAUER: Craig, these total margins are all-payer margins?

MR. LISK: Yes.

DR. REISCHAUER: And they exclude resources that hospitals might have from annual gifts, endowment earnings, parking?

MR. LISK: No, they would include those factors, too.

DR. REISCHAUER: They're included in here? Okay.

MR. LISK: The other thing to consider on the total margin though is that historically, and it's always been true, that major teachings total margins have always been lower. Unfortunately, I can't remember, this difference that we currently have may be about what has been in norm or it may, in fact, even be closer. You can't quote me on that because I don't have those numbers with me now.

But I know that the total margin increased from 1998, from when it actually did go down in the first year after the BBA.

DR. REISCHAUER: I have a presentation suggestion, and that has to do with the distribution charts that we get and, in a way, the tables, also. We have the first one, which is distribution of Medicare inpatient margins. It shows major teaching hospitals on the whole have much higher margins than others. And then you note well, they get some other kinds of payments, and disproportionate amounts of these other kinds of payments. And then you remove both DSH and above-cost IME.

I can see a good case for including another distribution table which just removes DSH. DSH is for something else. And then we want to ask ourselves well, for the payments that are really associated with Medicare, are we giving them in a sense too much and their margins are higher? And how much of this gap here, in these distributions, is due to IME above cost and how much to DSH?

If it's only a small amount, I'd say let's not lose a lot of sleep over it. I suspect it's not. I suspect, especially having heard those numbers for Ralph's hospital -- former hospital -- there must be some inefficiencies in having eight residents around each bed.

DR. LOOP: I think that we should study this further rather than making any recommendations now. The biggest problem is this is 1999 data, and teaching hospitals are probably not doing well in 2002. In fact there's a AAMC paper that suggests that half of the teaching hospitals will have negative margins this year. So I think we need an update on the plight of teaching hospitals before we make any conclusions.

There's one point that you made on page four in the last paragraph before issues. I was curious what documentation you have that teaching hospitals could negotiate lower payment rates with private payers because of the subsidy. I've not heard that

before and I know it's been discussed here. But do you have any documentation that that occurs?

MR. LISK: No, but it may also be evidence that they're paying the same rates as everybody else and not paying a premium, either.

DR. NEWHOUSE: That's what I was trying to get at by asking for the analysis.

DR. LOOP: I know you were. We always try to get higher payment rates with private payers and not negotiate lower payment rates. I just wondered...

MR. LISK: In terms of negotiation, it may provide some flexibility for the hospitals, given if they're looking at what their total bottom line is to negotiate what otherwise would be a lower rate. If they didn't get those rates, the hospital may end up being tougher in its negotiation with the private payers.

But there's no evidence of that. That's just theoretically what you would suppose would happen.

MS. BURKE: Craig, first of all, let me congratulate on summarizing what is a complicated history for our support of IME. But let me, if I can, underscore Bob's point to start with. I think in this analysis going forward, and whether we decide to do something this year or study it over a longer period of time, which I think makes sense, I think you have to separate out DSH from IME in the conversation.

They are two very different structures and two very different strategies. The decision to do one was very different from the decision to do the other. As is evidenced in the early part of your paper where you talk clearly about the fact that we, at the time of PPS, really weren't sure what it is we were doing as we sat around trying to draft that. And in fact, were trying to address what we believed to be an issue, the DSH scenario was a very different one.

So I think, first of all, let's separate these out in terms of conversation and talk specifically about what our intentions were with respect to IME.

I also think we can't underestimate, even as we try to do an analysis, of ultimately -- I mean, we can be helpful in providing information on what the numbers actually tell us. But at the heart of this is really the politics, of the support of a mission, that is the support of a particular mission that takes place in teaching hospitals in varying degrees and what Medicare's role ought to be in that broader mission.

I don't think anybody's confused about the fact that this is not always specific to Medicare patients. But we were very clear about our intention to essentially subsidize an activity that we believe helped the system broadly.

So I think we ought to be careful about assuming that's a pejorative because I don't think it was at the time that we did it. And I think we ought to be careful about making statements like well, this lets them negotiate lower rates. I don't think

the facts necessarily bear that out and I think we ought to be careful about how we state that, in terms of a basis upon which we'll make a decision on a rate.

So I think A, separate it from DSH. B, let's think about where we want to go with this. And C, let's recognize that a lot of this is the politics of the mission that was debated at the time and then nobody is confused about the fact this is all about Medicare. It's whether we use Medicare dollars for other purposes, which is exactly the point that Julian tries to raise as we have to get into that. But it's not just going to be a function of how numbers move around in terms of what those margins look like.

MR. LISK: On the DSH part, as we had talked about that back at the office, and unfortunately what we took was off-the-shelf stuff that we had done as part of our other analysis for doing this. Because we were very conscious about that issue.

MR. MULLER: I'll be very brief. I'll add to the DSH pile-on though. Obviously, since we add DSH revenues and not DSH costs, the margin is always going to look much higher in any table where there's a lot of DSH. I would just reiterate that point.

Secondly, remind me how we do the calculation of what the empirical level of costs are? You relate it to the IRB ratios? Just a brief description for me.

MR. LISK: Basically it's a regression analysis where the teaching component -- we account for other factors that are in the payment system that are cost-related factors, wage index, case-mix, and outlier payments, and those factors, and hospital location. And teaching adjustment picks up everything that's unexplained, basically.

MR. MULLER: Now is not the time for it but we know that the IRB ratio is the way in which the funds are distributed and people, for a long time, have been trying to figure out a better way of distributing it because I think everybody realizes it's a difficult way of distributing. Whether using IRB ratio is the best way, therefore trying to figure out what the costs are, I think is a point we should consider more fully.

I'll do that one offline but I do think it's not the best measure.

MR. LISK: That's always been an issue.

MR. MULLER: People can't easily come away with a better one, but there's a lot of inaccuracy, both on the payment side and therefore I would assume on the cost side, in using it. I don't have a better one at the moment, but I'm just saying we can't extrapolate too much therefore from using it as a kind of all else is attributed to that kind of variable.

DR. REISCHAUER: Craig, just to correct something that was wrong, the cost associated with uncompensated care, in other words the DSH costs, are included in the total margins.

MR. SMITH: Sheila made my point. Let me try to take this

back to the earlier conversation. Having a discussion about the appropriateness of the IME subsidy using margin data runs in the wrong -- runs away from what I thought you talked about sensibly 45 minutes ago. Sheila's point is we need to connect this conversation to the mission. We have no information about the appropriateness of the payment to the mission. It would be an enormous mistake working with simply margin data -- and one year's margin data as Floyd points out, a year which probably isn't very representative. To make a recommendation to cut these payments further seems to me enormously inappropriate at this point.

We ought to follow the let's put it off and study it, but we need to study it in the broader context. We won't be better off six months from now if we're still looking at annual margin and total margin and Medicare margin data in order to try to figure out whether this payment's appropriate. That's not why it's there.

DR. REISCHAUER: David, you aren't suggesting that we say that the cut that's supposed to go into effect in 2003 not go into effect, are you?

MR. SMITH: I didn't, but I might.

DR. REISCHAUER: I think Floyd was.

MR. SMITH: Ray made that point already and I'm not unsympathetic to that. But that wasn't my point, Bob. My point was we should not at this point recommend any additional cut or any pattern of going forward to try to reduce it to the empirical level.

MR. DEBUSK: David covered my point, but as a matter of curiosity, what is the dollar spin on indirect medical education payments above the cost of teaching? What is that value?

MR. LISK: Next year we estimated it's between $1.5 billion and $2 billion, is what we'd say for next year.

MR. DEBUSK: One other comment. How can we even begin to try to make decisions on some of this stuff when this data is ancient? It's so old it's, in many cases, useless.

DR. REISCHAUER: But that goes for almost everything we do.

MR. DEBUSK: Good point, Bob.

DR. ROWE: Can I ask, Bob, why you're so surprised at the concept of suggesting that the additional BBA dictated cut not occur? I mean, you really seem surprised by that.

DR. REISCHAUER: It is the law of the land, and Congress has assessed this issue two years in a row and pushed it off. And whatever evidence that we have right now suggests that even after this cut goes into effect there will still be substantial overpayment for IME. So I'm sort of saying okay, what's on the other side of this? And I think on the other side of this is we have old data and things are changing rapidly. That doesn't seem to stop us anywhere else.

MR. SMITH: But, Bob, part of the dilemma here --

DR. REISCHAUER: But if we did do what Jack suggests, we're

making a recommendation to Congress.

MR. SMITH: But in this case, the will of the Commission sounds to me not to make a recommendation to Congress. But the more important point is if what we were buying was IME, your point would make sense. But clearly, we're buying something else. And we don't know much. We don't know enough to say we don't want to pay what we're paying because we don't know enough about what we're getting and the appropriateness of this level of subsidy.

To argue that we ought to cut it because it isn't necessary to pay for IME ignores Sheila's very important point about how we got to where we are. We're not here because we're precisely price or cost the cost of medical education. That's not what we're doing.

DR. REISCHAUER: Sheila will tell you that we got where we were because we scared to death that PPS was going to savage these hospitals. And it turned out that it didn't. And in fact, some of them laughed all the way to the bank.

MR. HACKBARTH: We need to bring this to a conclusion. Clearly there's no consensus on this issue right now, so this is one we'll have to come back to later on. We have a lot of issues where we don't have that option of coming back later on and we've got to move on to those right now.

So thanks, Craig, for getting everybody awake and stimulated. Now we go into a series of presentations and discussions related to updates for fiscal year 2003.